SEVERE SURGE RESPONSE: CONTINGENCY STRATEGY RECOMMENDATIONS FROM *THE TASK FORCE FOR MASS CRITICAL CARE*

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TASK FORCE FOR MASS CRITICAL CARE

- **Diverse group of disaster preparedness experts**
  - **Physicians, nurses, pharmacists, respiratory therapists**
  - **Expertise in Critical Care, Pulmonary Medicine, Hospital Medicine, Emergency Medicine, Pediatrics, Trauma Surgery, Infectious Disease**
- **US and International members**
- **Mass Critical Care Surge Response during COVID-19: Implementation of Contingency Strategies.** A Preliminary Report of findings from the Task Force for Mass Critical Care
  - Accepted for publication: CHEST

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FOCUS: *STAYING WITHIN CONTINGENCY CARE!*
AVOID CRISIS STANDARDS WITH INCREASED MORTALITY

Decreasing ← Morbidity and Incident demands → Increasing

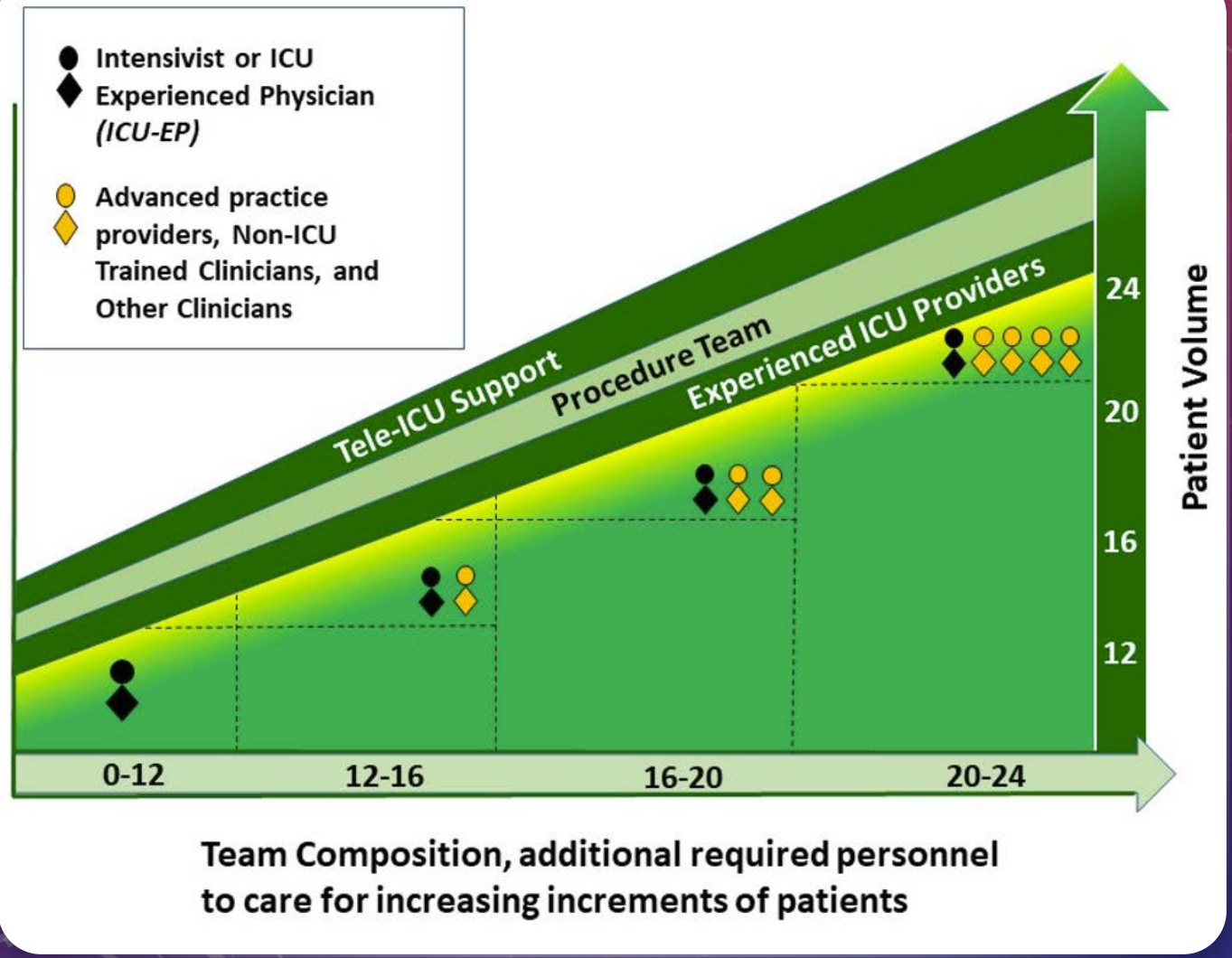
	Conventional	Contingency	Crisis
Space	Usual patient care spaces maximized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Non-traditional areas used for critical care or facility damage does not permit usual critical care
Staff	Additional staff called in as needed	Staff extension (supervision of larger number of patients, changes in responsibilities, documentation, etc')	Insufficient ICU trained staff available/unable to care for volume of patients, care team model required & expanded scope
Supplies	Cached/on-hand supplies	Conservation, adaptation and substitution of supplies with selected re-use of supplies when safe	Critical supplies lacking, possible allocation/reallocation or lifesaving resources
Standard of care	Usual care	Minimal impact on usual patient care practices	Not consistent with usual standards of care (Mass Critical Care)
ICU expansion goal	X 1.2 usual capacity (20%)	X 2 usual capacity (100%)	X 3 usual capacity (200%)
Resources	Local	Regional/State	National

Normal ← Operating Conditions → Extreme

STAFFING STRATEGIES

- Adapt alternative staffing models
  - Non-ICU personnel who can function in ICU with help (“force multipliers”)
  - Critical Care professionals embedded in and leading teams
- Focus on Resilience for all ICU staff
  - Accurate communication from organizational leadership and expressions of gratitude
  - Limiting overtime (< 50% above routine schedules)
  - Limit documentation (responsibly)

STAFFING OUR ICU'S

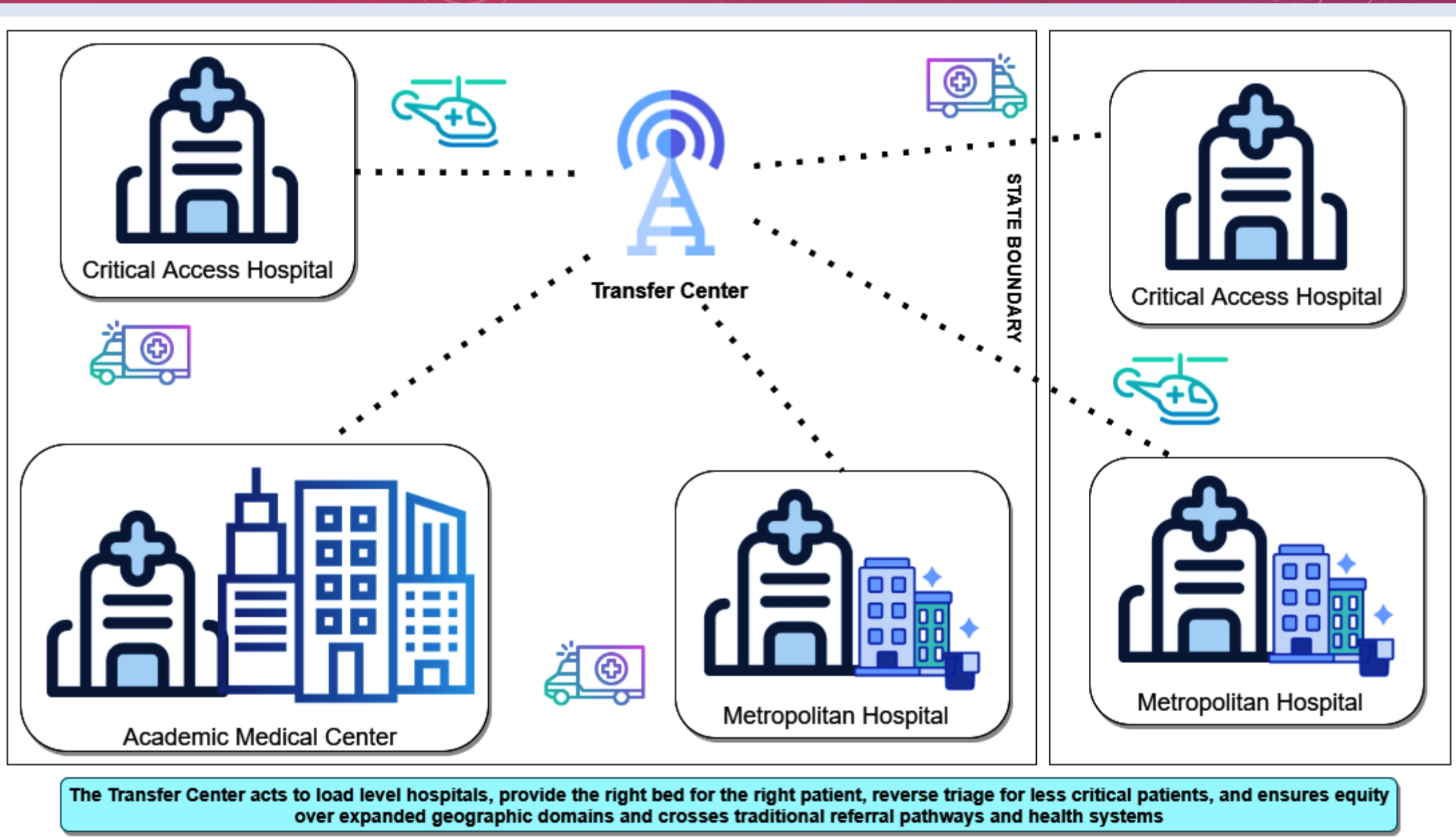


Provider model

Nursing Model

SURGE STRATEGIES

- **Identify when you are in trouble- nearing the limits of *contingency* resources**
- **Strain indicators:**
  - ***Patients waiting longer than 6 hours for an ICU bed*** **(mortality rises hourly)**
  - **Available ICU beds; amount of equipment (ventilators, dialysis, disposable supplies), oxygen, medications; available staff**
- **Response: Provide more resources (if available) or load balance (transfer) patients**
- ***Load Balance Early!!!***



The Transfer Center acts to load level hospitals, provide the right bed for the right patient, reverse triage for less critical patients, and ensures equity over expanded geographic domains and crosses traditional referral pathways and health systems

LOAD BALANCING STRATEGY: STATEWIDE COMMUNICATION AND COORDINATION CENTERS

- **Arizona, Washington, California, Minnesota (there are others)**
- **<u>Discussion points</u>**
  - **Contributions and importance of key stakeholders (Large health systems, Department of Health, State Hospital Association)**
  - **Do you need clinicians, administrators or both**
  - **Knowing where the staffed ICU beds are (technology vs. personnel)**
  - **What technology is needed?**
  - **Coordination across regions: daily conference calls; logistics of patient transfers over significant distance.**
  - **Can this really be set up in two (2) weeks?**